

# The Local Choice: Key Advantage With Expanded Benefits

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2013 – 09/30/2014

Coverage for: Individual/Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov) or by calling 1-888-642-4414.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                   | For in-network providers <b>\$100</b> person / <b>\$200</b> family<br>For out-of-network providers <b>\$200</b> person / <b>\$400</b> family<br>Doesn't apply to preventive care, outpatient diagnostic tests, outpatient prescription drugs or copayments | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No.  | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.  |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. For participating providers <b>\$1,000</b> person / <b>\$2,000</b> family<br>For non-participating providers <b>\$2,000</b> person / <b>\$4,000</b> family  | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| What is not included in the <u>out-of-pocket limit</u> ?  | Routine vision, dental, prescription drugs, premiums, any health care services this plan doesn't cover and balanced-billed charges   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Is there an overall annual limit on what the plan pays?   | No.  | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |

**Questions:** Call 1-888-642-4414 or visit us at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.thelocalchoice.virginia.gov](http://www.thelocalchoice.virginia.gov) or call 1-888-642-4414 to request a copy.

|  |  |   |
|--|--|---|
| Does this plan use a <u>network of providers</u> ? | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-552-2682 for a list of in-network providers. | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?  | No. You don't need a referral to see a specialist.   | You can see the <u>specialist</u> you choose without permission from this plan.   |
| Are there services this plan doesn't cover?        | Yes.   | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .   |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event  | Services You May Need                            | Your Cost If You Use an In-Network Provider | Your Cost If You Use a Non-Network Provider       | Limitations & Exceptions                                      |
|---|--|---|---|---|
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 copay                                  | 30% coinsurance after deductible                  | If you use a non-network provider, balance billing may occur. |
|   | Specialist visit                                 | \$25 copay                                  | 30% coinsurance after deductible                  | If you use a non-network provider, balance billing may occur. |
|   | Other practitioner office visit                  | \$25 copay for chiropractor                 | 30% coinsurance after deductible for chiropractor | Coverage is limited to 30 visits annual max for chiropractic. |
|   | Preventive care/screening/immunization           | No Charge                                   | 30% coinsurance after deductible                  | If you use a non-network provider, balance billing may occur. |

| Common Medical Event  | Services You May Need                          | Your Cost If You Use an In-Network Provider                         | Your Cost If You Use a Non-Network Provider     | Limitations & Exceptions   |
|---|--|---|---|--|
| If you have a test  | Diagnostic test (x-ray, blood work)            | 10% coinsurance   | 30% coinsurance after deductible                | If you use a non-network provider, balance billing may occur.  |
|   | Imaging (CT/PET scans, MRIs)                   | 10% coinsurance   | 30% coinsurance after deductible                | Pre-authorization may be required. If you use a non-network provider, balance billing may occur.   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.anthem.com">www.anthem.com</a> . | Generic drugs                                  | \$10 copay (retail); \$20 copay (home delivery)                     | \$10 copay (retail); \$20 copay (home delivery) | Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge. |
|   | Preferred brand drugs                          | \$20 copay (retail); \$40 copay (home delivery)                     | \$20 copay (retail); \$40 copay (home delivery) | Please see limitations in Generic drugs.   |
|   | Non-preferred brand drugs                      | \$35 copay (retail); \$70 copay (home delivery)                     | \$35 copay (retail); \$70 copay (home delivery) | Please see limitations in Generic drugs.   |
|   | Specialty drugs                                | \$35 copay (retail); \$70 copay (home delivery)                     | \$35 copay (retail); \$70 copay (home delivery) | Please see limitations in Generic drugs.   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | \$100 copay/visit   | 30% coinsurance after deductible                | —————none—————   |
|   | Physician/surgeon fees                         | \$15 copay for primary care physician and \$25 copay for specialist | 30% coinsurance after deductible                | —————none—————   |

|   |  |   |  |  |
|---|--|---|--|--|
| <b>If you need immediate medical attention</b>                                | Emergency room services                      | \$100 copay/visit   | 30% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur. | Copay waived if admitted.                                    |
|   | Emergency medical transportation             | 20% coinsurance after deductible                                    | 30% coinsurance after deductible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur. | _____none_____   |
|   | Urgent care                                  | \$15 copay for primary care physician and \$25 copay for specialist | 30% coinsurance after deductible   | _____none_____   |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | \$200 copay/stay  | 30% coinsurance after deductible   | _____none_____   |
|   | Physician/surgeon fee                        | No Charge   | 30% coinsurance after deductible   | _____none_____   |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | \$15 copay/visit  | 30% coinsurance after deductible   | _____none_____   |
|   | Mental/Behavioral health inpatient services  | \$200 copay/stay  | 30% coinsurance after deductible   | _____none_____   |
|   | Substance use disorder outpatient services   | \$100 copay   | 30% coinsurance after deductible   | _____none_____   |
|   | Substance use disorder inpatient services    | \$200 copay/stay  | 30% coinsurance after deductible   | _____none_____   |
|   | Employee Assistance Program (EAP)            | No Charge   | Not Covered  | Covers up to 4 visits per incident within a 12 month period. |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | \$15 copay for primary care physician and \$25 copay for specialist | 30% coinsurance after deductible   | _____none_____   |
|   | Delivery and all inpatient services          | \$200 copay/stay  | 30% coinsurance after deductible   | _____none_____   |

|   |                           |  |  |  |
|---|---------------------------|--|--|--|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | No Charge  | 30% coinsurance after deductible                                   | Coverage is limited to 90 visits max. per coverage period.   |
|   | Rehabilitation services   | 10% coinsurance after deductible                     | 30% coinsurance after deductible                                   | _____none_____   |
|   | Habilitation services     | 10% coinsurance after deductible                     | 30% coinsurance after deductible                                   | _____none_____   |
|   | Skilled nursing care      | No Charge  | 30% coinsurance after deductible                                   | Coverage is limited to 180 days max. per coverage period.  |
|   | Durable medical equipment | 20% coinsurance after deductible                     | 30% coinsurance after deductible                                   | _____none_____   |
|   | Hospice service           | No Charge  | 30% coinsurance after deductible                                   | _____none_____   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$25 copay   | Balance after \$50   | Limit one exam every 12 months.  |
|   | Glasses                   | \$20 copay for lenses, balance over \$100 for frames | Balance after \$50 for single lenses, balance over \$80 for frames | See your formal contract for complete details.   |
|   | Dental check-up           | No Charge  | Provider Charge in excess of plan's contractual rates              | Dental coverage administered by Delta Dental of Virginia, <a href="http://www.deltadentalva.com">www.deltadentalva.com</a> or call 1-888-335-8296. |

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care (except for some diabetic treatment – please see your member handbook for complete details)
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Dental care
- Most coverage provided outside the United States. See [www.anthem.com/tlc](http://www.anthem.com/tlc)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béesh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í hodiilní.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14<sup>th</sup> Street – 12<sup>th</sup> Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,000**
- **Patient pays \$540**

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |              |
|----------------------|--------------|
| Deductibles          | \$100        |
| Copays               | \$230        |
| Coinsurance          | \$60         |
| Limits or exclusions | \$150        |
| <b>Total</b>         | <b>\$540</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,420**
- **Patient pays \$980**

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |              |
|----------------------|--------------|
| Deductibles          | \$100        |
| Copays               | \$550        |
| Coinsurance          | \$250        |
| Limits or exclusions | \$80         |
| <b>Total</b>         | <b>\$980</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.